.100 INTRODUCTION

Abuse is defined as any practice that is inconsistent with accepted sound fiscal, business or professional practice which results in a claim, unnecessary cost, or payment for services or supplies that are:

1) not within the concepts of medically necessary and appropriate care, or
2) that fail to meet professionally recognized standards for health care providers.

The term "abuse" includes deception or misrepresentation by a provider or any person or entity acting on behalf of a provider in relation to a claim. Fraud is defined as (1) deception or misrepresentation by a provider, beneficiary, or any person acting on behalf of a provider or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized benefit to self or some other person, or some unauthorized payment, or (2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact.

.200 ANTI FRAUD AND ABUSE LAWS

Fraud in the United States' health care system is a serious problem that has an impact on all health care payers and affects every person in this country. There are several anti-fraud and abuse laws that affect the healthcare industry. They include, but are not limited to the False Claims Act, Whistle Blowers Act and the Health Insurance Portability and Accountability Act (HIPAA).

.210 FALSE CLAIMS ACT

The False Claims Act was amended in 1986 to improve the Government's ability to recover false or fraudulent payments. Now the Act imposes treble damages liability and civil penalties of $5,000 - $10,000 per claim plus three times the amount of the claim on any person who knowingly presents, or causes to be presented, a false or fraudulent claim for approval to the U.S. Government. It prohibits the submission of a false or fraudulent claim and/or making a false statement or representation in connection with a claim. The Act is the primary means of recovering

damages for losses to the Medicare Trust Fund (and other government sponsored programs). It is also the primary means of recovering fraudulently claimed dollars from health care providers, including hospitals. To prove liability, the Government must show actual knowledge of falsity, reckless disregard for truth or falsity, or deliberate ignorance of truth or falsity. "Deliberate ignorance" reaches those who consciously ignore or fail to inquire about readily discoverable facts that would alert them that a given claim is false. Billing errors due to simple negligence, mistakes, or inadvertence are actionable under the False Claims Act. The government must prove at a minimum a "deliberate ignorance" or a "reckless disregard" of the truth or falsity of the claims submitted by the provider.

.220 WHISTLE BLOWERS ACT

Whistle Blower's Act – The "Qui Tam" provisions of the False Claims Act, referred to as the "Whistle Blower's Act", was also amended in 1986 and provides for the incentive for whistle blowers to overcome the substantial detriment and obstacles to speaking out. Often, a whistle blower is a health care employee with inside knowledge of wrongdoing. When he/she blows the whistle, he/she invariably becomes an outcast in the industry. However, the qui tam provisions allow such whistle blowers to act as private attorneys general and bring suit under the False Claims Act seeking recoveries against defrauders of government programs. The whistle blower may share in any recoveries by the federal government of those providers found to have committed fraud.

.230 POSTAL FRAUD

Postal Fraud – The U. S. Postal Inspection Service is the law enforcement branch of the U.S. Postal Service, empowered by federal laws and regulations to investigate and enforce federal statutes related to crimes against the U.S. Mail, the Postal Service and its employees. Postal inspectors investigate any crime in which the U.S. Mail is used to further a scheme, whether it originated in the mail, by telephone or on the Internet. The use of the U.S. Mail is what makes it a mail fraud issue.

.240 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Health Insurance Portability and Accountability Act (HIPAA) – In 1996 Congress and the President authorized the Fraud and Abuse Control Program under the Health Insurance Portability and Accountability Act.

The program is designed to provide a framework and resources to coordinate Federal, State, and local law enforcement efforts. It mandates a comprehensive program of investigations, audits, and evaluations of health care delivery; authorizes new criminal, civil and administrative remedies; requires guidance to the health care industry about potentially fraudulent health care practices; and establishes a national data bank to receive and report final adverse actions imposed against health care providers.

.300 REPORTING FRAUD AND ABUSE

Each agency has procedures for reporting fraud and abuse. Consult the individual carrier's provider manual for specific information on how to report fraud and abuse.

Department of Medical Assistance Services
Trailblazers
TRICARE
Anthem Blue Cross Blue Shield
U.S. Postal Service
Centers for Medicare & Medicaid (CMS)